



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MARK H. HENRY, MD

Respondent Name

GRANITE STATE INSURANCE CO

MFDR Tracking Number

M4-15-3135-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

MAY 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We find that none of the services billed on the claim were paid at 100% for he statutory fee as required by law per Texas Administrative Code Title 28 Part 2 Chapter 134 Subchapter C Rule 134.202. The attached medical records adequately support each of the services provided and is sufficient to warrant payment as set forth by the aforementioned section of the Texas Administrative Code. Additionally, the attached explanation of benefits (EOB) from the carrier clearly shows that they are continually denying all services provided to the patient during his 9/24/2014 office visit with the rational of **services were partially or fully furnished by another provider**. Please review the paid amounts as they pertain to the MAR (maximum allowable Reimbursement) for the services submitted."

On August 24, 2015, the Division spoke to the requestor's representative, Elizabeth, that stated payment had not been received for the disputed services and they remained in dispute.

Amount in Dispute: \$161.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that the 9/24/2014 date of service was paid in accordance the fee guidelines/schedule for the billed procedure codes (29130, 73140 and Q4049) and that the \$161.11 that has been requested by Dr. Henry has already been paid back on 2/9/2015."

Response Submitted by: AIG Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24, 2014	CPT Code 29130-LT Application of finger splint; static	\$85.39	\$65.52
	CPT Code 73140-LT Radiologic examination, finger(s), minimum of 2 views	\$71.58	\$53.18
	CPT Code Q4049-LT Finger splint, static	\$4.14	\$2.58
Total		\$161.11	\$121.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - Procedure/service was partially or fully furnished by another provider.
 - A reduction was made because a different provider has billed for the exact services on a previous bill.
 - Workers Compensation State Fee Schedule adjustment.
 - Workers compensation jurisdictional fee schedule adjustment.
 - Only one visit or consultation per physician per day is covered.
 - The code does not comply with the definition of a physician service and cannot be reimbursed using physician fee schedule. (Medicare)
 - The charge is either a partial or complete duplicate to another charge for the same service on the same date by the same provider or a different provider.
 - Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - The provider has billed for the exact services on a previous bill.
 - The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
 - The charge is either a partial or complete duplicate to another charge for the same service on the same date by the same provider or a different provider.

Issues

1. Is the requestor entitled to reimbursement for codes 29130, 73140?
2. Is the requestor entitled to reimbursement for HCPCS code Q4049?

Findings

1. The respondent states in the position summary that "the 9/24/2014 date of service was paid in accordance the fee guidelines/schedule for the billed procedure codes (29130, 73140 and Q4049) and that the \$161.11 that has been requested by Dr. Henry has already been paid back on 2/9/2015."

On August 24, 2015, the Division contacted the requestor to verify that payment was received and services remained in dispute. Per the requestor's representative, Elizabeth, payment has not been received and services remain in dispute.

A review of the submitted documentation finds insufficient documentation to support that payment was made to the requestor; therefore, reimbursement per 28 Texas Administrative Code §134.203(c)(1)(2) is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The place of service indicated on the bill is 11 for a Doctor's office.

The 2014 DWC conversion factor for this service is 55.75.

The Medicare Conversion Factor is 35.8228

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77044, which is located in Houston, Texas; therefore, the Medicare participating amount is based on locality "Houston, Texas".

Using the above formula the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement (MAR)	Total Insurance Carrier Paid	Total Due
29130	\$42.10	\$65.52	\$0.00	\$65.52
73140	\$34.17	\$53.18	\$0.00	\$53.18

2. 28 Texas Administrative Code §134.203(d)(1)(2) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

- (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

HCPCS code Q4049 has a fee schedule of \$2.07; therefore to determine the MAR $\$2.07 \times 125\% = \2.58 . The respondent paid \$0.00. As a result, \$2.58 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$121.28.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$121.28 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	08/26/2015 _____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.